Working Alliance Inventory-Short Form Revised

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Summary

The 36-item Working Alliance Inventory, based on Bordin's theory, was developed in 1989 to measure the strength of the therapeutic alliance.[1] Later, a 12-item form, the Working Alliance Inventory-Short Form Revised (WAI-SR) of the WAI was developed.[2] The WAI-SR has similar clinimetric properties as the 36-item version.[2] The short form requires less time to complete, and is therefore less burdensome for patients and more appropriate for repeated measurements over time in clinical practice and research.[2] The WAI-SR measures three domains of the therapeutic alliance: (a) agreement between patient and therapist on the goals of the treatment (Goal); (b) agreement between patient and therapist about the tasks to achieve these goals (Task); and (c) the quality of the bond between the patient and therapist (Bond).[3] A key aspect of the therapeutic alliance is that it requires active negotiation and participation between patient and therapist.[3]

The WAI-SR is a patient-rated questionnaire. Patients rate items on a 5-point Likert scale anchored at each end with 'rarely or never' (1) and 'always' (5). The Goal, Task and Bond domains each have scores ranging from 5 to 20. Higher scores indicate a better therapeutic alliance. Completing the WAI-SR takes about 5 minutes.

Validity, reliability and responsiveness: The WAI-SR has high internal consistency; Cronbach's α of the subdomains range from 0.81 to 0.90, and Cronbach's α of the total score is 0.91.[2,4] The WAI-SR has high reliability, with test-retest reliability of 0.93 (95% CI 0.83 to 0.97).[5] With regard to construct validity, the WAI-SR correlates well with other therapeutic alliance measures; $r = 0.80$ with the California Psychotherapy Alliance Scale and $r = 0.74$ with the Helping Alliance Questionnaire.[2] Furthermore, higher scores on the WAI-SR are associated with better treatment outcomes, confirming the WAI-SR's construct validity in accordance with Bordin's theory.[6,7] The distinction between the Goal and Task domains has consistently failed in confirmative factor analyses. This suggests that these two domains are measuring similar constructs; an interpretation that is supported by the high correlations between the Bond and the Goal and Task factors. For this reason, many researchers recommend using the overall mean of the WAI-SR rather than its subscales.[8]

Commentary

The WAI-SR is a reliable, valid and widely used tool for measuring therapeutic alliance.[9] It is both easy and quick to use. Although the WAI-SR is the most frequently used tool to assess therapeutic alliance, the questionnaire was originally developed and validated for psychotherapy. It was not specifically designed for use in physiotherapy and rehabilitation practices;[9] therefore, it might fail to account for aspects of the physiotherapy or rehabilitation therapeutic alliance. For instance, the WAI-SR does not capture the implications of physical touch and contact during treatment. Yet touch is often a core component of the treatment interaction between therapist and patient[10] in physiotherapy and rehabilitation practice.

The mean WAI-SR scores are high in most studies.[2,4,7] This suggests possible ceiling effects, although these have not been explicitly measured in clinimetric studies. Ceiling effects may affect the responsiveness of the WAI-SR. Domain scores provide insights into which aspects of the therapeutic alliance could be improved. In these cases, ceiling effects are less relevant. Clinically, the WAI-SR can be used if therapists have doubts about the therapeutic alliance in their treatment relationship. Patient scores can be helpful for discussing the therapeutic relationship in order to improve it.

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References

1. Horvath AO, et al. *J Couns Dev.* 1989;36:223–233.
2. Hatcher RL, et al. *Psychother Res.* 2006;16:12–25.
3. Bordin ES. *Psychother Theor Res Pract.* 1979;16:252–260.
4. Munder T, et al. *Clin Psychol Psychother.* 2010;17:231–239.
5. Hanson WE, et al. *Educ Psychol Meas.* 2002;62:659–673.
6. Falkenström F, et al. *J Couns Psychol.* 2013;60:317–328.
7. Ferreira PH, et al. *Phys Ther.* 2013;93:470–478.
8. Falkenström F, et al. *Assessment.* 2015;22:581–593.
9. Hall AM, et al. *Phys Ther.* 2010;90:1099–1110.
10. Kayes NM, et al. *Disabil Rehabil.* 2012;34:1907–1911.

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